STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445408	A. BUILDING _____ B. WING _____	05/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SODDY-DAISY HEALTH CARE CENTER	701 SEQUOYAH ROAD SODDY-DAISY, TN 37379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During complaint investigation number TN00027109, conducted on May 23, 2011 through May 25, 2011, at Soddy Daisy Healthcare Center, no deficiencies were cited in relation to the complaint under 42 CFR PART 482.13, Requirements for Long Term Care.	F 000	This plan of correction is submitted as required under state and federal law. The submission of this plan of correction does not constitute an admission on the part of Soddy Daisy Healthcare Center to the accuracy of the surveyor's findings nor the conclusions drawn therefrom. The facility's submission of this plan of correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied.	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164	1. Resident # 3 was assessed on May 25, 2011 by the Director of Nursing and Social Services related to privacy. The resident's physician assessed the resident on May 25, 2011. No adverse outcome was identified. The Treatment Nurse was in-serviced on privacy by Director of Nursing on May 24, 2011. 2. All residents with wounds were assessed by the Director of Nursing and the Medical Director on May 25, 2011. No adverse outcomes were identified. No other residents were affected by the practice.	5/31/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Rick Mbrity — administrator — 6/7/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

JUN 09 2011

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F 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure privacy during a dressing change for one resident (#3) of twenty-four residents reviewed. The findings included: Observation of the resident in the resident's room on May 24, 2011, at 9:25 a.m., revealed the Treatment Nurse providing a dressing change to resident #3's buttocks in the view of resident #24. Continued observation revealed the Treatment Nurse completed the dressing change. Interview with the Treatment Nurse in the treatment nurse office on May 24, 2011, at 9:56 a.m., confirmed the Treatment nurse failed to ensure privacy during a dressing change.	F 164	3. All licensed nursing staff and certified nursing assistants were in-serviced on providing privacy to all residents during care May 25, 2011 through May 30, 2011 by the Director of Nursing, Assistant Director of Nursing, and/or Nursing Supervisor. 4. Observations audits for providing privacy for residents during wound care to be monitored by Director of Nursing, Assistant Director of Nursing and/or Nursing Supervisor one time per shift per day for 7 days, then one time a day for 14 days, then 3 times a week for 4 weeks, then one time a week for 5 weeks and/or 100% compliance. All results of the above will be reported by Director of Nursing quarterly to the Quality Assurance Performance Improvement committee comprised of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, Restorative Nurse, Medical Records, Minimum Data Set Coordinator, Rehab Director, Social Services, Activities, Dietary Manager, Environmental Services Supervisor, and Maintenance Director.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation,	F 314	1. Resident #3 was assessed on May 25, 2011 by the Director of Nursing and by the resident's physician. No adverse outcome identified. The Treatment Nurse was in-serviced on policy and procedure for wound care by Director of Nursing on May 24, 2011.	5/31/11

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F 314	Continued From page 2 facility policy review, and interview, the facility failed to follow the facility's policy for Infection Control during a dressing change for one resident (#3) of twenty-four residents reviewed. The findings included: Resident #3 was admitted to the facility on May 10, 2011, with diagnoses including Above Knee Amputation, Diabetes Mellitus, Anemia and Stage 3 Wound. Medical record review of a physician order dated May 12, 2011, revealed "...cleanse...L (left) Buttock Pressure Ulcer with wound cleanser. Apply Ca (Calcium) Alginate top with foam and affix with opsite..." Observation of the resident in the resident's room on May 24, 2011, at 9:25 a.m., revealed the Treatment Nurse providing a dressing change to resident #3. Observation revealed the Treatment Nurse removed the visible soiled dressing and placed into a red biohazard bag for disposal. Continued observation revealed the resident touched the visible wet wound with the right hand and then touched the face. Further observation revealed the Treatment Nurse returned to the already established clean field, failed to wash the hands or change the gloves, obtained gauze and wound cleanser and cleaned the wound. Review of the facility's policy for "Treatment of Pressure Sores, Chapter 3" revealed "...5. Remove soiled dressing...Remove gloves and discard...6. Wash hands...7. Apply new gloves...8. Cleanse wound..."	F 314	2. All residents with wounds were assessed by the Director of Nursing and the Medical Director on May 25, 2011. No other residents were affected by the practice. 3. All licensed nursing staff and certified nursing assistants were in-serviced on appropriate hand hygiene per policy and procedure on May 25, 2011 through May 30, 2011 by the Director of Nursing, Assistant Director of Nursing, and/or Nursing Supervisor. 4. Observations audits for following wound care to be monitored by the Director of Nursing, Assistant Director of Nursing or Nursing Supervisor one time per shift per day for 7 days, then one time a day for 14 days, then 3 times a week for 4 weeks, then one time a week for 5 weeks and/or 100% compliance. All results of the above will be reported by Director of Nursing quarterly to the Quality Assurance Performance Improvement committee comprised of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, Restorative Nurse, Medical Records, Minimum Data Set Coordinator, Rehab Director, Social Services, Activities, Dietary Manager, Environmental Services Supervisor, and Maintenance Director.	

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F 314	Continued From page 3 Interview with the Treatment Nurse in the treatment nurse office on May 24, 2011, at 9:56 a.m., confirmed the Treatment Nurse failed to maintain infection control by not cleaning the resident hand after the resident touched the wound, and by not following the facility policy on Treatment of Pressure Sores.	F 314		